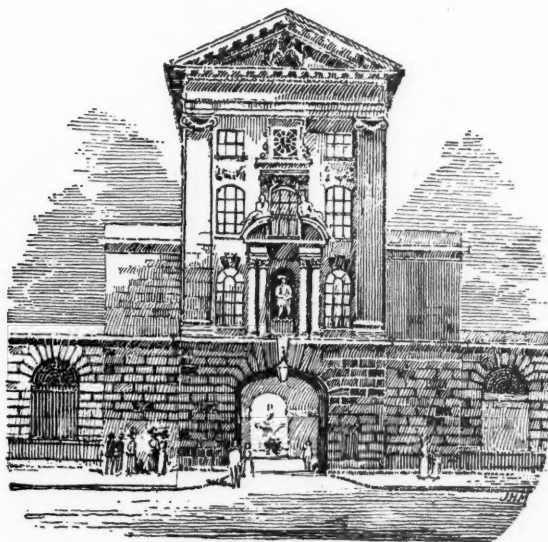


SEP 13 1922

# ST BARTHOLOMEW'S HOSPITAL JOURNAL



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# St. Bartholomew's Hospital



"Æquam memento rebus in arduis  
Servare mentem."

—Horace, Book ii, Ode iii.

## JOURNAL.

VOL. XXIX.—No. 12.]

SEPTEMBER 1ST, 1922.

PRICE NINEPENCE.

### CALENDAR.

Tues., Aug. 29.—Dr. Drysdale and Mr. McAdam Eccles on duty.  
Fri., Sept. 1.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.  
Tues., „ 5.—Sir T. Horder and Sir C. Gordon-Watson on duty.  
Fri., „ 8.—Prof. Fraser and Prof. Gask on duty.  
Tues., „ 12.—Dr. H. Morley Fletcher and Mr. Waring on duty.  
Fri., „ 15.—Dr. Drysdale and Mr. McAdam Eccles on duty.  
Tues., „ 19.—Sir P. Horton-Smith Hartley and Mr. Rawling on duty.  
Fri., „ 22.—Sir T. Horder and Sir C. Gordon-Watson on duty.  
Tues., „ 26.—Prof. Fraser and Prof. Gask on duty.  
Fri., „ 29.—Dr. H. Morley Fletcher and Mr. Waring on duty.

### EDITORIAL.

**T**HE Professorial Units have been in the past seriously hampered by the lack of adequate accommodation for their pathological work. We hope that soon this will be remedied, for the Council to the Trustees of the late Sir William Dunn has recently granted (under certain conditions) £10,000 to the Hospital for the purpose of establishing and maintaining suitable laboratory accommodation. The whole of the present Isolation Block will be devoted to the Professorial Units, and a bridge will be built between the first floor and Sandhurst Ward.

Thus should two thoroughly alive Hospital departments be able to extend their influence. They have so far necessarily devoted themselves in a very large measure to becoming valuable teaching units. It now remains to be seen whether, with their new accommodation, the fruits of this teaching and its inspiration, may be demonstrated in the production of sound research.

\* \* \*

The Sub-Committees appointed in connection with the Eight Hundredth Centenary Celebrations have now issued their reports.

The Religious Services Sub-Committee recommends that the Festival should begin with a celebration of the Holy Communion, followed by two special services, one in St. Paul's Cathedral, the other in the Church of St. Bartholomew the Great, one at the beginning, the other at the end of the Festival; and that there should be a procession from the Hospital to St. Bartholomew the Great or possibly to St. Paul's.

The Exhibitions Sub-Committee has prepared a provisional grouping of books, prints, maps, etc., which will be exhibited in the Great Hall.

The Scientific Sub-Committee will publish a Commemoration Volume containing an historical account of the Hospital by Sir D'Arcy Power, and a statement of its future needs by Mr. Waring. It is proposed in the report that a competition be held under the direction of the President of the Institute of British Architects to provide architectural plans for rebuilding the Hospital, with prizes not exceeding £1000 in amount. We understand, however, that this scheme will very probably be found unworkable, and that a single architect may be asked to furnish plans instead.

The Entertainment Sub-Committee proposes to reproduce the Bartholomew Fair (as held in Elizabethan days), in the Square, together with various luncheons, dinners, and a *conversazione*.

The chief points of interest about the report of the Reception Sub-Committee are its determination to invite delegates from English-speaking universities only, and the fact that there will be no expenses in connection with their work.

Regarding these proposals as a whole there can be no doubt that this important anniversary will be adequately celebrated.

\* \* \*

The pleas for the gradual reconstruction of the Hospital should perhaps be as interesting and instructive as anything

in the programme; for which of us has not conjectured upon what plan the Bart.'s of the future will be built? On the one hand is the urgent necessity of advancing with advancing science. To stand still in this case is to go back. An ancient institution tends always to rest upon its laurels. We must expand in all directions or fail to maintain our position.

On the other hand is the real affection felt by all Bart.'s men for these old buildings which have seen so much of hope and suffering, recovery and death, success and failure. There is no doubt, however, that in the direct issue sentiment would have to go. It is the healing of the sick with the maximum efficiency which is all important, and the vital problem is the wisest possible use of existing ground space.

We imagine that the present suggestions for reconstruction are an attempt to combine the ideas of modern ward hygiene with the advantages, sentimental and real, of a great teaching centre in London. This rebuilding, if it comes, will be a huge business. Possibly yet another way may be found. It may be that, since we cannot expand in area, we may have to go higher. The top wards in each block might well be demolished, several stories of new wards with up-to-date and elaborate hygienic and pathological arrangements instituted, and on the top, high above the dust and roar of the London streets, a flat roof, connecting block to block by bridges, and providing roof gardens for the patients and tennis courts for nurses and students.

We who are at Bart.'s now cannot but feel that the Hospital is at the very crest of a great wave of prosperity and of public esteem. There are many reasons for this, but the first and most important, for which we should be profoundly thankful, is the wise, cautious, and yet bold administration of those at the head of the Medical College and Hospital during and immediately after the trying war years. They who met those problems will be able to meet the extraordinary difficulties suggested by the Octocentenary Prize.

\* \* \*

We are relieved that the memorandum proposes the Bartholomew Fair is to be "as it was held in the Elizabethan Period." There will be about twenty-five side-shows, some resembling those which took place at Bartholomew Fair and some "of a more modern character." To brighten up Queen Elizabeth, we presume.

We believe that it was in the days of Good Queen Bess that Bartholomew Fair was visited by the first man who took the trouble to describe it—one Paul Hentzner—who, after visiting Germany, France, Italy and England, wrote an "Itinerarium," after translated by Bentley for Horace Walpole:

"It is worthy of observation that every year upon St. Bartholomew's Day, when the Fair is held, it is usual for

the Mayor, attended by the twelve principal aldermen, to walk in a neighbouring field dressed in his scarlet gown, and about his neck a golden chain to which is hung a golden fleece, and, besides that particular ornament which distinguishes the most noble Order of the Garter, when the Mayor goes out of the precincts of the City a sceptre and sword and a cap are borne before him, and he is followed by the principal aldermen in scarlet gowns with gold chains, himself and they on horseback. Upon their arrival at a place appointed for that purpose, where a tent is pitched, the mob begin to wrestle before them, two at a time; the conquerors receive rewards from the magistrates. After this is over a parcel of live rabbits are turned loose among the crowd, which are pursued by a number of boys who endeavour to catch them with all the noise they can make. While we were at this show one of our company, Tobias Salander, Doctor of Physic, had his pocket picked of his purse, with nine crowns, which, without doubt, was so cleverly taken from him by an Englishman who always kept very close to him that the Doctor did not perceive it."

There was, however, a darker side. Five years before this visit the Fair was forbidden because of plague; five years later it was closed again. Hentzner's description of Queen Elizabeth is interesting: "In the fifty-sixth year of her age (as we are told), very majestic; her face oblong, fair but wrinkled; her eyes small, but black and pleasant; her nose a little hooked, her lips narrow, and her teeth black (a defect the English seem subject to from their too great use of sugar). . . . She wore false hair, and that red; her bosom was uncovered, as all the English ladies have it till they marry; her hands were small, her fingers long, and her stature neither tall nor low; her air was stately; her manner of speaking mild and obliging."

Yes, Elizabeth's time is the period for the Fair!

\* \* \*

Early in August the Hospital was shocked to hear of the tragic death of Estlin Hugh Weatherall, an obituary of whom will be found elsewhere. A man of great promise, of a gentle spirit and surveying life with level eyes, his was a personality which can ill be spared. Readers of the Journal will miss in him one of the writers of the witty articles signed "Gemini." We extend our deepest sympathy to his sorrowing family.

\* \* \*

At the adjourned inquest held on August 16th last a verdict of "death from misadventure" was returned. Weatherall was riding pillion fashion when the accident occurred. Any practising surgeon well knows the danger of this form of riding, whilst the motor-cyclist is compelled to realise it by the greatly increased premium demanded when insuring a machine if a pillion-passenger is to be

carried. We believe that pillion riding should be made illegal. Several times already the question has been raised in Parliament. Each time no action has been taken.

\* \* \*

Our congratulations upon the following honours: Lt.-Col. F. O'Kinealy, C.I.E., I.M.S., Chief Medical Officer to the Prince of Wales during his recent tour, has been made a C.V.O.

Sir Anthony Bowlby has been elected President and Sir D'Arcy Power Vice-President of the Royal College of Surgeons of England during the ensuing year.

Messrs. H. E. Griffiths, G. L. Keynes, L. B. Rawling and E. M. Woodman have been appointed Hunterian Professors.

\* \* \*

Our congratulations to the following Bart.'s men who have been elected to Junior Beit Fellowships:—*Ernest Basil Verney*: Proposed research, "The Physiology and Pathology of Urinary Secretion," at the Institute of Physiology, University College, London. *Reginald Hilton*: Proposed research, "The Study of the Blood Gases in various stages of Pulmonary Collapse produced by Artificial Pneumothorax; the Condition of the Circulation in the Collapsed Lung." Place of research, the Laboratory and Wards of the Professorial Unit of St. Bartholomew's Hospital.

\* \* \*

Ivan de Burgh Daly was elected to a fourth year fellowship for his research on "Auriculo-Ventricular Block."

\* \* \*

Amid the congratulations of many friends, Dr. F. J. Waldo has just completed twenty-one years' service as Coroner of the City of London and Southwark.

Dr. Waldo's public work dates back long before he went to the City. For many years he was the first Medical Officer of Health to the Two Temples and in the old Borough of Southwark, and had to face some of the hard problems presented by slumdom in its worst phases. The old Tabard Street area—one of the very worst in London—was "on his beat," and it was largely due to his efforts that clearance was at last made.

Through his action, too, the sewage-sodden "cellar" bakehouses of Southwark and other low-lying districts and insanitary underground bakeries were legislated for, and the Salvation Army shelters placed under the Common Lodging Houses Act.

To us at Bart.'s he is well known as an old friend and an old Lecturer to the Hospital.

\* \* \*

It is an Englishman's privilege to grumble at his food, but we are glad that never yet have we discussed in the Journal the affairs of the Catering Company; partly because we have noticed that almost every hospital journal in

London has its recurring grumble at its own restaurant, and chiefly because we believe that on the whole the Catering Company does very well indeed. It is, however, a pleasure to be able to praise whole-heartedly an innovation. In place of a particularly monotonous tea menu there is now such luxury as an epicure could desire. Some great mind has done this thing. Lest, however, the Catering Company should vaunt itself we would tactfully suggest that the same mind will have considerable scope in considering our breakfast diet.

\* \* \*

Few events in the Hospital have recently been so generally acclaimed with approval as the proposal of the Vicar to hold a Parish Festival on Bartholomew's Day, August 24th. It is to us a matter of pride that the Hospital is a parish in itself, and his parishioners will be glad indeed to meet their Vicar and each other "in some other place besides the Church and the wards"—a touch in his invitation which has led to many a quiet chuckle.

We congratulate Mr. Dunkley on the wisdom and inspiration of this move, and, writing some days before the meeting, look forward "with sure and certain hope" to a pleasant evening.

\* \* \*

As we go to press we are able to express our thanks to the Vicar for a delightful evening, wholly free from constraint and stiffness. Where all who performed were good, Mr. Catford's singing requires special mention.

May we hope that Mr. Dunkley will organise other "parish festivals"? Such an opportunity for the meeting together of all resident in the Hospital fills a long-felt lack in our social life.

## THE QUESTION.

What is life but a flower that's blown,  
And proudly its colours doth wear;  
Whose fragrance awhile fills the air,  
Then is gone?

What is life but a comet alight  
In the darkness of Time; that doth boast  
An effulgence supreme, then is lost  
In the night?

What is life but a song that is sung,  
And with sweetness enchanteth the ear;  
Whose passionate rapture we hear  
Not for long?

What is life but a vision soon fled,  
That appeareth to us in a dream;  
Whose transient glory doth gleam,  
Then is sped?

## OBITUARY.

ESTLIN HUGH WEATHERALL, M.B., B.S.(Lond.),  
M.R.C.S., L.R.C.P.

**I**T is with more than ordinary sorrow that we record the death, at the age of 24, of Estlin Weatherall, Junior House-Physician to the Medical Unit. Many at the Hospital will feel not only the tragedy of it, but also a deeper sense of personal loss. Weatherall was spending his fortnight's holiday as M.O. of a Boys' Own Brigade Camp at Deal. He was killed on August 1st, in a motor-cycle accident at Ramsgate. The motor-cycle on which he was riding pillion collided with a char-à-banc at a blind corner, and he was thrown off and killed instantly. He was the son of the Rev. J. H. Weatherall, of Notting Hill Gate, was educated at Bolton Grammar School, and joined this Hospital in January, 1916. He was undoubtedly one of the most brilliant men of his year: he gained an Entrance Scholarship in Arts, a Senior Scholarship in Anatomy and Physiology, the Wix Prize and the Burrows and Skynner Prizes. He qualified M.R.C.S., L.R.C.P. in January of this year, and took his London M.B. in May, obtaining distinctions in Medicine, Forensic Medicine and Midwifery. Inclining at first to surgery, he took the Primary Fellowship "in his stride"; but later he turned to medicine and was appointed last April as Junior House-Physician to the Medical Professorial Unit. During the war he served for six months as a surgeon-probationer, and found his feet at once, having a natural love for the sea and ships. The success of the Abernethian Society last session was very largely due to his energy as Secretary; he was elected President in March, but only once took the Chair, when his excellent speech in introducing Mr. Bernard Shaw will be remembered by all who heard it. He was Vice-President of the Debating Society, where he not infrequently spoke with sound sense and humour. A sense of humour was, indeed, one of his characteristics, as were a modest and gentle nature and a rigid sense of honesty. We can never know what Medicine and the Hospital have missed by his death; we only know what his colleagues on the Junior Staff and other friends at the Hospital have lost, and above all our sympathy goes out to his family. Those of us who knew him best feel that we are the better for having known him, and that his life, though short, has not been in vain.

C. H. A.

## THE OCTOCENTENARY OF THE FOUNDATION.

### 4. PITCAIRN WARD.

By SIR D'ARCY POWER, K.B.E.

**O**F the many who enter our Wards the names denote only their position in the block; they connote nothing at all. For them Pitcairn, Abernethy, Lawrence and Stanley are as much abstractions as Faith, Hope and Charity, yet each should remind us of those great men who helped to bring the Hospital and the School to its present position in the world of Medicine. The Pitcairns, uncle and nephew, were successively Physicians to the Hospital, and both by their occasional lectures on medicine began systematic teaching on the medical side at a time when Pott and Abernethy were developing it surgically. By mere perversity Pitcairn is a surgical rather than a medical ward, although neither of its namesakes had any use or experience in this branch of their art.

There is but little to be said of William Pitcairn, the uncle. Born in 1711, he studied under Boerhaave at Leyden, graduated M.D. at Rheims, acted as private tutor to the Duke of Hamilton at Oxford, made the grand tour with him, received the M.D. of Oxford when the Radcliffe Camera was opened in 1749, and then settled in London. He was elected Physician to the Hospital in 1750, rose rapidly to eminence and fortune, and was President of the College of Physicians from 1775 until 1785. He resigned his office of Physician in 1780 and was appointed Treasurer of the Hospital in 1784. He lived in Upper Street, Islington, where he had a garden of five acres, which was only surpassed in London by that of Dr. John Fothergill at Upton near Stratford-by-Bow in Essex. He died in 1791, and was buried in our Hospital Church. We think of him as a learned and successful physician of a type which was then not uncommon.

It is far otherwise with his nephew—David Pitcairn—who still lives for us as a man as well as a doctor. A loveable man, we are told, tall, erect, and strikingly handsome in his youth, and retaining his good looks to his life's end: one of those to whom his friends and colleagues always turned for help and advice in time of sorrow, need, sickness, or any other adversity. His manner was simple, gentle and dignified; from his kindness of heart he was frequently led to give more attention to his patients than could well be demanded from a physician, and as this evidently sprung from no interested motive, he often acquired considerable influence over those whom he attended during sickness. No medical man indeed of his eminence in London perhaps ever exercised his profession to such a degree gratuitously, says one who knew him personally. Besides, few physicians

ever gained so extensive an acquaintance with the various orders of society. He associated much with gentlemen of the law, had a taste for the fine arts, was a fellow of the Royal Society as well as of the Society of Antiquaries.

Born in Fife in 1749, he was the younger son of John Pitcairn, a major of marines, who was killed at the Battle of Bunker's Hill, though his body is buried in our Hospital Church. His elder brother Robert, as by an accident, gave his name to Pitcairn Island, where the crew of the "Bounty" afterwards made a home.

David was educated at the High School, Edinburgh, and at Glasgow, before his uncle sent him to graduate in medicine at Corpus Christi College, Cambridge. He obtained his M.B. degree in 1779, and was elected Physician to the Hospital in the following year, a post he resigned, says Sir Norman Moore, in 1793. He was admitted a Fellow of the College of Physicians in 1785, and was five times Censor. Whilst he was at the Hospital he continued and improved the medical teaching, and brought it into line with the reformed methods introduced by John Abernethy on the surgical side. It is reported traditionally that in the course of these lectures he first drew attention to the fact that valvular disease of the heart was a frequent result of rheumatic fever. Subject to repeated attacks of quinsy and suffering from hæmoptysis, he left England in 1798, and spent eighteen months in Portugal, where he so far recovered his health that he returned to England, took a house in Lincoln's Inn Fields, then a fashionable neighbourhood, and continued to practise. On April 13th, 1809, he had an acute attack of cedematous laryngitis, which appeared to present unusual characters to his friend Dr. Matthew Baillie, who was called in to attend him. Reading Dr. Baillie's account by the light of modern knowledge, it would appear to have been an acute streptococcal infection of the nature of Ludwig's or Vincent's angina. He died at his house in Craig's Court, Charing Cross, three days later, and is buried with his father and uncle in the Church of St. Bartholomew's the Less.

Pitcairn was one of the distinguished line of physicians who carried the gold-headed cane which is now a treasured possession of the Royal College of Physicians. Belonging originally to Radcliffe, it passed to Mead, Askew, for a short time to William Pitcairn, to David Pitcairn, who gave it to Matthew Baillie, Hunter's nephew, who bequeathed it in turn to Sir Henry Halford. Becoming garrulous in its old age the cane wrote the story of its experiences when it was in the possession of its successive masters. The book proved to be so entertaining that it was several times reprinted.

## CHRONIC GASTRO-INTESTINAL CATARRH IN CHILDREN.

By T. H. G. SHORE, M.D., M.R.C.P.



UT-PATIENT experience must sooner or later lead to the conviction that the common diseases are the most important, and in children of all ages the commonest are probably the minor disorders of the gastro-intestinal tract. Unfortunately the symptoms of which the parents complain are most varied, and often their bearing is not obvious, so that the underlying condition shared by a large group of patients is apt to be overlooked, and treatment meted out rather to the symptoms than to the disease.

Such diverse complaints as fidgeting, lassitude, lack of interest in meals, especially breakfast, wasting, sleep-walking, cough, worms, pallor, jaundice and nocturnal enuresis, to mention only a few, may ultimately be referable to catarrhal disorders of the gastro-intestinal tract.

Chronic gastro-intestinal catarrh probably has its origin in improper and irregular feeding in the earlier years of life, though it is between the ages of four and twelve that it is most often met, when it is kept up by the parental ignorance and carelessness which started it. Children who have irregular meals, with odds and ends between meals, and sweets to keep them quiet, are the sort which have chronic catarrh. The mode of life is partly the cause of the trouble and partly the result. The catarrhal child is peevish and irritable, and will not eat at the proper times, and is then given cakes, biscuits or sweets between meals, under the belief that food is needed to overcome the common symptom of wasting. The result is quite otherwise, for the child continues to waste, and we hear that his food does him no good. Such irregular feeding with carbohydrates only keeps up the condition, which passes from bad to worse. Chronic gastro-intestinal catarrh often seems to start as a legacy from some other state of catarrh such as whooping-cough or measles; hence the advisability of a proper restoration of health by a change of air after such diseases.

In its simplest form "the derangement consists in an increased secretion of mucus from the whole internal surface of the alimentary canal; it is a mucus flux which interferes mechanically with digestion and absorption of food, and by its influence impedes general nutrition," to quote Eustace Smith. The immediate result of this is to lower functional activity throughout the alimentary canal; digestive juices are poured out in smaller amount, muscular tone is diminished and peristalsis less effectual. The presence of mucus is often to be demonstrated in the vomit or in the stool. From this simple but general catarrh extension occurs to neighbouring organs in communication with the alimentary tract, the bile-ducts and pancreatic duct, and its reflection is seen—a pale, flabby, indented

tongue, with pharyngitis and perhaps chronic bronchitis as well.

After such a prefatory description the commoner symptoms are easy to explain. The mucous coating over the interior of the stomach leads to imperfect gastric digestion and allows of fermentation; the result is discomfort after food due to wind, and consequent refusal to take much at a time. This is often construed as a lack of appetite, but sometimes parents will say that the child is ravenous but soon satisfied. He is, however, ravenous again before the next meal is due. This type of gastric dyspepsia causes pain "under the heart," and some children suffer from nausea and occasional vomiting or "bilious attacks"—not to be confused with cyclic vomiting. Catarrh in the duodenum produces discomfort from flatulence, often leads to jaundice from catarrhal involvement of the bile-passages, and doubtless also to pancreatitis, though this is not so easily detected. From the small intestine flatulence and gurgling are the chief symptoms, and abdominal distension may be pointed out by the child's mother.

Among the most characteristic symptoms of the condition are those due to chronic catarrh of the colon. The cæcum may become distended with gas, and colic arises from spasm or irregular peristalsis further on. Constipation is common, as also is looseness of the bowels, and the two states often alternate. The stools contain quantities of mucus, either mixed up with faecal material or occurring separately as masses of jelly: slimy mucous coats over the surface of small, hard, dark-coloured scybala, which may be retained for days owing to the slippery surface interfering with the muscular propulsion. Such faecal masses sooner or later lead to local irritation in the rectum or higher up, which is relieved by an attack of diarrhoea, during which much mucus is passed with perhaps a little blood. Undigested food, such as portions of vegetable matter, raisins, currants, carrot, fragments of orange and so on, often pass practically unchanged. They have gradually worked their way through the intestine, and have been protected by an envelope of mucus from the action of the digestive juices. Prolapse of the rectum is not uncommon in these patients, and appendicitis is often seen.

Malnutrition naturally results from the "mucous disease," as Eustace Smith called this condition. Younger children get labelled "consumptive bowels," though the factor of tuberculosis does not exist; in older children it is often erroneously suspected. The patients become pale, complain of abdominal discomfort, lose weight and appetite, and may sweat at night, though not to the extent that is seen in the head sweating of rickets, or the more general sweating of tuberculosis or sepsis. The presence of some bronchitis may lend support to the graver diagnosis, but pyrexia is not commonly present. Fainting at school is common in such children. It is in these patients that pica, or a perverted appetite, is sometimes met. Some children

will eat dirt, coal, orange-peel, garden worms, or even brown paper. In any case the appetite is uncertain, and often difficult to accommodate. Usually such children prefer carbohydrates, and in some the dietary consists of little else.

Another common manifestation of the mucous state is the presence of threadworms, or less often of the round worm or whip-worm. Worms are not in themselves to be regarded as a disease and treated as such, but only as a sign of disease. They do not find lodgment in a healthy bowel, but the layer of mucus coating over the lining of the colon in these children forms an ideal nidus for their existence; it adds greatly to the difficulty of their complete removal. The life-history of these worms is as yet only imperfectly understood. How they enter the body, whether or not there is an intermediate host, and if so what it is, and consequently the rational prophylactic treatment, are at present unknown. It is easy to suppose, as is commonly taught, that children reinfect themselves by ova lodged under the finger-nails by scratching to relieve pruritus ani, but recent work shows that the larval stage has to be far advanced if the young worm is to survive the gastric juice after it has been swallowed. Some believe that the larvæ of ascaris pass through the lung, just as those of ankylostoma, the miner's worm, do. The same may be the method adopted by the thread-worm, though the balance of opinion seems to be against it. At any rate one cannot believe that irritation of the nose is provided by Nature at the psychological moment in order that the child may scratch and reinfect itself. It seems much more likely that there is something in the noses of infected children to produce irritation, and that may well be larvæ at some stage of their migration. Children infested with worms frequently suffer from a cough, which becomes worse when increases in the number of worms occur. Other symptoms due to the irritation of worms are restlessness at night, which may amount to somnambulism, vulvo-vaginitis, and even fits or a mild choreic condition.

From what has been said it is evident that chronic gastrointestinal catarrh is responsible for a great deal of minor illness of a very diverse nature. The effects of the condition on the health of a growing child are, however, farther reaching than this. A child so afflicted grows up to be "delicate" and peevish, and later may become a nuisance to himself and others by his fads and fancies with regard to food; he may grow up a hypochondriac. A constipated habit often has its origin in this condition. Catarrh in the colon may lead to chronic colitis, with changes in the mucous membrane and musculature of the bowel, to the formation of piles, and more remotely to infections of the urinary tract, which may be extremely difficult to eradicate. Pyelitis in children frequently arises in this way, and may persist into adult life. Oöphoritis and some forms of dysmenorrhoea in later life may well have their beginnings in chronic gastro-enteritis of childhood.

The treatment in an early case is comparatively easy, but when the condition has been established for some years it is by no means so simple, and considerable ingenuity may be needed to make the child submit to a radical change of diet. The diet, of course, is the most important consideration. The chief change consists in great reduction in the amount of carbohydrate taken, for this is the main cause of fermentation and production of flatulence. It would do no harm if all carbohydrate but bread were cut off, and even that were restricted in amount. More protein, in the form of milk, meat, and eggs is needed. Fat is probably not being taken in excess, for these children are "bilious." "What we have ourselves," though doubtfully suitable as an adult dietary, is certainly not suitable to a young child. As important as the nature of the food is the regularity with which it is taken. Meals should be at regular times, three or four a day according to the age of the child, and nothing should be allowed between meals. A potent source of trouble is the carbohydrate meal in the middle of the morning at school. One's popularity with the patient must suffer by forbidding the consumption of sweets. A point to remember, at any rate in the hospital class of child, is a regular warm bath at night, for this helps to restore the functional activity of the skin, which becomes dry and harsh in these cases. General health picks up more rapidly if this is attended to. A proper amount of exercise and plenty of fresh air are essential.

Medicinal treatment is begun by giving alkali (sodium bicarbonate) in fair doses before each meal, and this may well be combined with a bitter such as calumba or gentian (haust. calumbæ alk., St. B. H.). This mixture should be given 10 or 15 minutes before food, three or four times a day, according to the number of meals thought advisable. Alkali given in this way tends to detach or dissolve mucus from the gastric mucosa, and perhaps from further down the alimentary tract. A regular mild aperient at night will help by removing periodically the mucus so detached. A suitable powder or tablet is one containing equal parts of powdered rhubarb and hydrarg. cum creta, the dose being adjusted to particular requirements (pil. hyd. c. cret. et rhei, St. B. H.). In some cases aloes or senna are suitable.

Other than the simple manifestations require treatment on their merits. Worms need santonin, or rectal injections of quassia or common salt. Bromide is indicated in certain nervous states, and so on, but no expectation of cure must be entertained unless the underlying condition has been dealt with along the lines indicated.

A tonic, such as iron or cinchona, may be needed later on, but by far the best is a change of air to a bracing seaside place.

## INSANITY IN ITS RELATION TO CRIMINAL LAW.

By J. G. PORTER PHILLIPS, M.D.(Lond.), F.R.C.P.



SOCIETY throughout all its evolutionary stages, in order to keep law and order within its pale, has been compelled to adopt punitive measures of varying severity and thus protect itself from chaos and dissolution.

For centuries past our legal system, founded upon the wisdom of Roman law, has steadily developed and improved, with the result that law, as taught and practised in England at the present day, has attracted the admiration of all nations.

As a peace-loving citizen one has to accept the rulings of those responsible for the framing and administration of the law, knowing full well that any deviation from the ordinary paths can only be obtained by alteration of the law as it stands upon our Statute Book by recognised constitutional methods.

The recent outburst of public opinion, incensed with emotional feeling, but lacking true technical perspective, regarding the alleged mal-administration of the criminal law in the case of murder, has resuscitated an old bone of contention between medicine and law.

The responsibility which devolves upon the shoulders of every citizen may be considered either from the civil or criminal point of view.

Responsibility as a term is a purely legal one and means liability to punishment. Criminal responsibility furthermore may be interpreted as the liability to punishment for crime, and the legal test of the latter rests on the question of the knowledge of right and wrong.

One can discuss the question of insanity in any particular case only when the mental health of an individual is queried. A conflict of opinion must necessarily result, as the test of responsibility in the legal sense does not harmonise with that formulated by psychologists. Unfortunately both the legal and medical experts are constantly juggling with the word "insanity," and yet have failed so far to define exactly this fluctuating and nebulous state of mind.

In the first instance, reviewing these complex problems, it is well to differentiate between mental disorder and insanity, as both terms are not infrequently wrongly used by the uninitiated.

Insanity cannot manifest itself without the existence of mental disorder, whereas mental disorder can exist in no small measure without the incidence of insanity. Many men and women carry out their civil duties of life whilst suffering from a disordered mind, and continue to do so

without arousing much, if any, suspicion as to their abnormal mental mechanism. On the other hand, insanity, being essentially based upon the disorder of conduct (and language), very soon manifests its presence by the individual concerned entering into conflict with his or her social surroundings.

This is undoubtedly the juncture at which interest, criticism and often aimless discussion are aroused when we have to consider the question of responsibility in relation to crime. Here we are faced with a difficult and controversial matter in having to differentiate between the legal and medical interpretation of the question, whether the accused was capable of knowing what was morally right from what was morally wrong, and *not* whether the individual was in a condition to know whether that which he was doing was legally wrong.

At once we find ourselves insidiously involved with the problem of defining moral sense and moral discrimination. These two latter terms, each having its respective definition and value, cannot be discussed in detail, but suffice it to say the former is an inherited or instinctive quality, whereas the latter is that attribute which is evolved and further elaborated from the innate moral sense by means of environment and education, with its corrective influences in the form of punishment.

The relation of insanity to criminal law has always been unsatisfactory, the medical or psychological views being opposed to those held by the Legislature.

Judicial opinion as existing to-day has been the outcome of controversy and discussion, which resulted from the well-known MacNaughton case which attracted so much public attention in 1843.

In this case the question of insanity and its bearing on the administration of the criminal law was raised.

One named MacNaughton, who had apparently been suffering from mental disorder for some little time with prominence of persecutory delusions, was arrested for murder. He imagined that a system of persecution instigated by the Home Secretary of that time was directed against him and endangered his very existence. Filled with morbid suspicion and apprehension he lay in wait for Sir Robert Peel, but mistaking the identity of his secretary, Mr. Drummond, he shot at and killed him instead, in the full belief that he was the Home Secretary, and thus the person responsible for the plot against him.

The prisoner was found to be insane and acquitted, which resulted in an outburst of public feeling.

The case was then considered by the House of Lords and judicial opinion was sought. After much deliberation and discussion, the now famous MacNaughton dictum or ruling was framed. This judicial ruling may be summarised as follows:

If a person suffers from a delusion but is *not* otherwise insane, he is held to be responsible for his offence *unless* he

has acted in such a way as would have been permissible had the facts about which his delusion exists been true. Thus, should a person, suffering from a delusion that another is about to kill him, kill the other individual (in self-defence), the former is not held to be responsible.

On the other hand, should the delusion be that he is being simply robbed, then in this case the deluded person is deemed responsible.

Generally speaking, when a plea of insanity is urged it has been laid down that if at the time of committing the offence the accused, labouring under such defect of reason from disease of the mind, did not know the nature and quality of the act he was committing, he cannot be deemed responsible for that act, and if he did know and did not understand he was doing what was wrong, again he is not deemed responsible for that crime.

The concept of crime in a general sense must necessarily be a social rather than a biological one.

In order to study this accurately and thus be able to formulate appropriate and efficient measures for its check, one must, wherever possible, scrutinise very carefully the past as well as the present stock-in-trade of the unfortunate culprit, such as total inheritance, his mental make-up, environment and impelling influences at work.

Thus when the problem of criminal responsibility arises the whole "worldly" setting of the case should be ascertained, carefully analysed, and considered judgment given in each individual case.

In view of the fact that public attention has been strongly focussed on a recent murder trial it may be interesting to some readers to review the case.

It will be seen that the law, usually so clear, definite and just, in this instance is entirely responsible for the paradoxical state of affairs which has unfortunately arisen.

Public opinion in many instances is the outcome of calm, deliberate and logical reasoning based on practical experiences of life, but more often the judgment formed is coloured by sentimental tone, which, stimulated by indignation, may assume a state of emotional ebullition.

In this instance hostile criticism and scathing comments were directed against the various individuals responsible for the proper conduct of the case subsequent to the sentence of death being passed on the accused man.

This particular case has certainly proved a paradox owing to the inflexible and adamant attitude of the law. By the existence of a law which was enacted as far back as the reign of Henry VIII it has been ordered "that an insane man shall not go to execution"

At the trial the plea of insanity was rejected by judge and jury, perhaps due no doubt to the fact that the accused *did* understand the nature and quality of the act for which he was indicted. Later the Court of Criminal Appeal firmly upheld the verdict. According to the dictates of common sense and morality nothing now remained but for

the law to proceed with its capital punishment, but unfortunately for public opinion the law was compelled to intervene in favour of the convicted, and thus stultify its previous carefully considered judgment.

According to the Section 2 (4) of the Criminal Lunatics Act, 1884, the Home Secretary is forced to institute an inquiry into the state of mind of the condemned man, *i.e.*, after sentence has been passed, should the question of insanity be brought to his notice.

It is obvious, then, as far as this particular case is concerned, the law provides a paradoxical state of affairs, and one which is not only opposed to the teachings of common-sense, but also deletes its own ruling.

As far as medical witnesses at the trial are concerned it is their simple duty to give an unbiassed and honest opinion as to the mental state of the accused at the moment he committed the crime, *i.e.*, whether the prisoner understood the nature and quality of the crime, and, if he did, did he understand that what he was doing was morally wrong.

Although the question of the prisoner's previous history does not actually count, yet it usually influences the verdict of the jury.

As pointed out above the medical practitioners specially appointed by the Home Secretary to inquire into the state of mind of the condemned man (after sentence) did so and made a report thereon.

After carefully reviewing all the above facts it would appear that the law is wrong as at present constituted.

Although it is obvious in such a case that medical views must be seriously considered, yet the Legislature cannot justly state that "crime will not abate if the infliction of the penalties of the law is left to the experts of Harley Street."

The time has now arrived when there must be a definite *rapprochement* between the medical and legal authorities regarding the interpretation of insanity in its relation to criminal law.

Since the above lines were penned the Lord Chancellor has appointed a Committee of Inquiry, composed of prominent members of the legal profession, to investigate what changes, if any, should be made in the administration of criminal law.

## NOTES ON THE NURSING OF PNEUMONIA.

**P**NEUMONIA is one of the diseases in which nursing is somewhat more important than medicine in aiding the patient towards recovery. It often happens that when the recently qualified man goes either to a small hospital to become a house-physician, or enters the strenuous profession of a private practitioner, it

becomes necessary for him to order the nursing as well as the medical treatment; hence these notes on the nursing of this common complaint.

### Position.

Keep lying flat, with one pillow, unless the patient wishes to sit up.

### Clothing.

Let the patient wear a cotton garment, open down the back (to avoid difficulty in changing it when necessary), a light blanket over the feet, sheet and quilt, till the temperature has fallen.

### Washing.

The patient should be gently rolled into a blanket morning and evening, and thoroughly sponged all over, taking about 10 minutes over the process. It is much more comfortable and soothing to use very hot (about 110° F.) rather than tepid water.

### Back.

Owing to distress caused to a pneumonia patient by moving him, it is often only possible to attend to his back morning and evening when he is being sponged, and as it is a short illness the back rarely gives rise to any real anxiety. It should be washed with plenty of soap and water, well dried, rubbed with hazeline solution or methylated spirit, and powdered with starch powder. An air ring will add to the patient's comfort if it can be obtained.

### Care of

### Mouth.

The mouth must be attended to before and after every feed. If the patient is able he may rinse it out with some warm mouth-wash such as listerine or glycothymoline and water. Usually it is necessary for the nurse to cleanse it with wisps of wool wound round a bit of stick; the best solution for this purpose is sod. bicarb. 3j dissolved in water 3v. Listerine may be added if the mouth is offensive or the patient dislikes the taste. A little ung. hydrarg. nit. dil. rubbed over the lips will keep them from becoming uncomfortably dry.

### Food.

The patient must be fed regularly every 2 hours by day and as nearly every 4 hours by night as can be done without waking him. He should be given citrated milk 3iij (sod. citrate gr. j to every 3j of milk), with glucose or sugar 3j and 3ij of coffee, tea, water, soda-water, or chocolate (1 oz. of chocolate dissolved in 3ij boiling water). or one egg beaten (two in 24 hours), arranging the feeds so as to get variety in flavour, and water, lemonade, or soda-water 3vj every 2 hours, alternately with milk feeds. As much more fluid should be given as the patient will take, but milk feeds must *not* be increased in either time or quantity, or digestive troubles will arise. A little custard, jelly, or thin bread and butter is permissible if the patient will take it. Feeds may be cold or hot as desired.

The times of medicines, stimulants and **Medicines.** hypodermic injections should be arranged so that they do not come together. If brandy and strychnine are being ordered, give them 4-hourly alternately so as to keep up the stimulant effect. Never

put brandy into a feed, as, if all food is not taken, the patient has not had the amount of stimulant ordered.

A pneumonia patient should never be awakened for *any* treatment; nothing is so important as sleep. Have feeds, medicines, injections, etc., absolutely ready so that the moment he wakes whatever is due may be given and he may go to sleep again as quickly as possible. A pneumonia patient rarely sleeps for more than 2 hours without waking, so that a good nurse will get nourishment as well as treatment given.

If the temperature reaches 105° F. it is advisable to cradle, leaving the patient in a cotton shirt, with a light blanket over the feet as far up as the knees. Put two large body cradles over him and cover him over with a sheet, leaving both ends open, and tucking the sides under the mattress firmly, as most patients will pull the sheet over them if left untucked. If the feet are cold put on sleeping-socks. Outside hospital cradling is not possible on account of opposition of relatives; then only one sheet must be left covering him. If the temperature reaches 104° F. sponging must be carried out, proceeding as for the morning and evening process, but continuing for twenty minutes. The very hot water will bring the temperature down just as well as tepid and will not cause discomfort to the patient. The patient should be dabbed dry with a soft towel, not rubbed, and left cradled, his temperature being taken half an hour after sponging is finished to see how much it has fallen.

A rectal tube will sometimes relieve this condition, but usually an enema gives more relief; it should be given without turning patient, so that as little disturbance as possible is caused.

Though helpful to some patients, others are terrified by it, considering it the signing of their death-warrant. Should it worry the patient, discontinue it at once; *any* treatment which worries a patient is harmful.

Nothing relieves the pain of pleurisy so rapidly as leeches. Should it be necessary to apply them, place a piece of lint with small holes cut in it over the painful area, seeing that the apertures are over ribs, so that pressure can be applied later. Put each leech into a test-tube that has been blocked about 1 in. from the top with a plug of cotton-wool; invert the tube over the hole in the lint and hold fairly firmly till the leech has become attached; draw the test-tube gently away, and the leech will rest on the lint, so that the patient will not feel its clamminess. If it will not bite, put a little sweet milk on the skin. Should this fail to attract the beast, lightly scratch the skin with a sharp needle; should this fail, discard the refractory leeches and try others. When they have dropped off (it usually takes about three-quarters

of an hour for them to dine) put on a fomentation of four-fold lint, renew in 20 minutes, then firmly strap on leech pads. Bleeding will rarely occur; if it should do so, soak the first layer of the pad in 1-1000 adrenalin and strap a halfpenny firmly over the outside of pads. (A leech pad is made of four layers of double lint in graduated circles, the smallest about the size of a threepenny-bit, largest the size of a halfpenny, inside the smallest layer of lint a wisp of gauze, as the blood clots more easily by this device.) If it be necessary to remove the leeches, put some salt on their heads and they will drop off. Do not let the patient see the leeches; arrange a curtain or towel to obstruct the view.

As the time comes when the crisis is likely, the patient must be watched very carefully for the first sign of sweating.

Usually this occurs first over the chest; less often on the forehead. Put on two blankets, a hot bottle to the feet if weather be cold, and give hot drinks—coffee is very useful, or some hot brandy and water may be advisable. When the patient has ceased to sweat, rub down quickly with a hot towel, and put on a warm dry shirt, and fresh sheets if required. Frequently the temperature drops considerably below normal, and the pulse is infrequent; no anxiety need be felt, provided the patient seems comfortable; it will soon recover the normal level when more nourishment is taken. As soon as the crisis is over, let the patient take any digestible solid food that he will, and discontinue 2-hourly feeds.

#### CHILDREN UNDER THE AGE OF ABOUT 10 YEARS.

The nursing of young children differs considerably from that required for adults.

A child can always lie down, and should be tied down to prevent it throwing a strain on the heart by sitting up and moving about.

Light cotton garments, bedsocks if feet tend to become cold, or a light blanket over feet, sheet and quilt.

Sponging night and morning as for adult, but only 5 minutes is necessary for a small child.

It is always necessary for the nurse to cleanse the mouth, as even the older children cannot usually be made to rinse out their mouths properly.

Give the same type of food as for adults, the quantity being modified to suit the child's age; it is often not possible to get it to take the whole of the feed at the proper time; try then to get the quantity taken in small drinks during the 2 hours. A child should always be awakened for feeds (4-hourly by night) as it will sleep again at once, and will very quickly get into regular habits. If feeds are persistently vomited as soon as taken, give the child a drink of water, the same

quantity as its feed, which will be vomited, then give feed *immediately*; it will nearly always be retained.

**Temperature.** Cradling can be carried out as for adults, but if the temperature reaches  $104^{\circ}$  it is easier in infants and little ones up to three years or so to put them into a bath at the bedside at a temperature of  $100^{\circ}$  F. and reduce to about  $95^{\circ}$  for 10 minutes. The child should be supported on nurse's arm, and water sponged over chest; submerging the chest might embarrass respiration, besides being liable to frighten child.

**Restlessness.** Small children are often marvellously soothed by a hot bath. Proceed as above, but keep temperature of water at  $100^{\circ}$  F.

**Cyanosis.** Infants whose chests sound full of "rattles," who are intensely cyanosed and seem absolutely overwhelmed with their disease, are often much relieved by a mustard bath (mustard 2 tablespoonfuls, well mixed into a thin paste with cold water and added to 2 gallons of water) at a temperature of  $100^{\circ}$  F., gently increasing to  $105^{\circ}$ . Usually 5 or 6 minutes is long enough to keep them in it.

**Sleep.** Children should be awakened for feeds and necessary treatment.

**Crisis.** Treat on the same lines as for adult patients; little children rarely sweat, and often sleep through the actual fall of temperature, which may be very rapid—from  $104^{\circ}$  to  $96^{\circ}$  F. in 3 or 4 hours. It is only rarely that anything more than extra clothing and hot drinks are required.

Never cradle *any* patient, either adult or child, no matter what the temperature may be, if sweating is present.

## THE PERSIAN GOVERNMENT HOSPITAL, TEHRAN.

By A. R. NELIGAN, M.D.(Lond.), M.R.C.S., L.R.C.P.,  
D.T.M. & H.(Cantab.),

Physician to the British Legation and Medical Officer to the Hospital.



NOTE appeared in the Journal during 1919 to the effect that the British Government had undertaken to assist the Persian Government to reorganise this Hospital, and to that end had placed the services of Dr. J. Scott, Medical Superintendent of the Indo-European Telegraph Department, and of myself, at its disposal. We entered on our duties on June 1st, 1919, and as my colleague left Tehran on leave six weeks later, I was the only permanent medical officer at work during most of the first nine months of the reorganisation, and think that a short account of what has been done may interest St. Bartholomew's men.

The Hospital was opened in 1869 and had a Persian

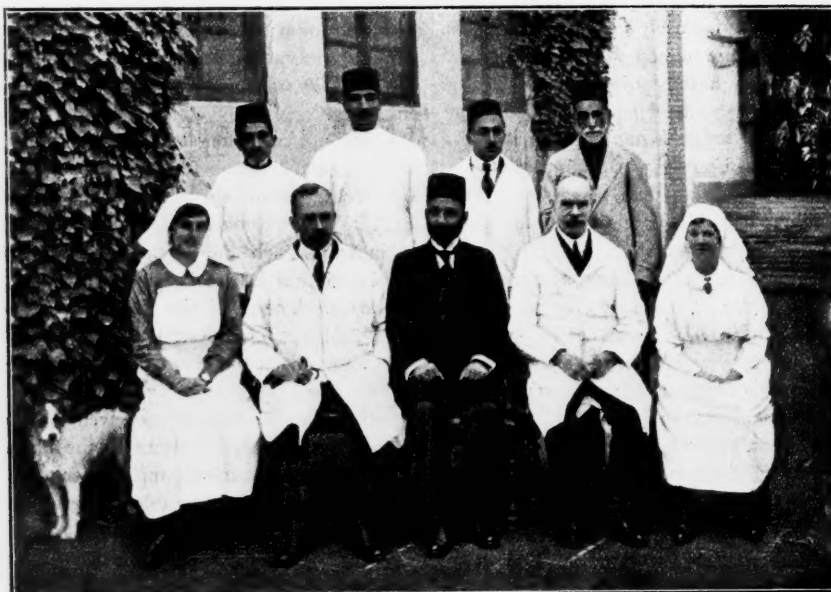
staff until 1896, when the doctor of the German Legation was put in charge of it. Later a second German was appointed as his assistant. This arrangement lasted until November, 1915, when the Turkish Embassy and the German and Austrian Legations left Tehran in the expectation that the Shah would follow them, and thus bring Persia into the war against us. After an anxious day for the Allies in Tehran, His Majesty decided to take the advice of the British and Russian Ministers, and sent away his travelling carriage. The German Legation did not return, and the Hospital passed into Persian hands again, and a Persian Director, the senior of the court physicians, was appointed. For a time the Russian Red Cross had the use of half the beds for their force in North-West Persia, but the institution steadily deteriorated, and in 1919 was taking in not more than thirty in-patients, and this in a city of over 200,000 people with hundreds of villages in the environs.

I shall not easily forget the day on which we took over, for I spent the night before in the desert, some thirty miles from Tehran, with my wife, two friends, half the sand-flies in Asia and a broken-down Ford car, the result of an attempt to reach the Caspian Gates, the scene of the assassination of Darius III during his pursuit by Alexander (330 B.C.). The relief van which came to find us landed us at the Legation a short hour before the time fixed for my appearance at the Hospital, white with dust and quite unpresentable. However, I arrived in time, and Scott and myself were most cordially received by the Director, Dr. Hakim ed Dowleh, Physician to the Shah, and the staff. It may be said that our appointment had been received very favourably indeed by the local profession and Persians in general.

The Hospital is situated in a main thoroughfare, and the tramway passes the door—a fact of importance for the poor in a city which covers some sixteen square miles. It used to stand in large grounds but most of these have been sold, and the area covered by the institution to-day is about two hundred yards long by sixty yards wide, about half of which is garden. There is a handsome covered entrance, which, like that of another hospital, bears the name of a King, Nasr ed Din Shah. Rooms on either side accommodate the gate-keeper, the armed guard and the gardener. From it a straight drive leads through the garden to the building. On the right is a bungalow which was later fitted up for the English matron, and, nearer the Hospital on the other side, is a construction which holds the steam disinfecter. The Hospital proper is built, like most Persian houses, round a paved courtyard. It is entered from the garden by a handsome portico, on the domed ceiling of which is carved in plaster the Prussian Eagles, as well as the "Lion and the Sun." In the centre of the court is the usual large tank (no fountain with restful rim!), and round it are sunk beds with trees and shrubs. The general effect

is most pleasing. The buildings are on one floor raised about four feet from the level of the court. They have domed roofs (a common thing in Persia, where timber for rafters is scarce) and immensely thick walls, and consist of a series of small rooms, no one of which takes more than eight beds. They were lighted by low windows on the side towards the court, and there was a huge dead air space in each dome. One of our first improvements was to make top lighting and ventilation. Between the wards on the north side of the court and the boundary wall is a smaller compound, in which were eight small rooms for paying patients at one end, and next them two large storerooms.

The clean operating theatre is on the south side of the courtyard and is exceedingly good for Persia. It is very well lit and lofty. The floor and the walls for five feet up are tiled with white tiles, and the corners are rounded off with specially made tiles. There were locally made glazed basins and sinks, with a hot and cold tap for each, operated by the elbow, but unconnected, and the cold water not sterilised. We subsequently altered the boilers so as to sterilise the cold water, and connected the taps so as to be able to wash in running water of any desired temperature. It should be stated that there is no piped water supply at Tehran, and that therefore the water of the Hospital has to



*Back row :*

DR. ANAYATULLAH KHAN	DR. HUSSEIN KHAN	DR. HUSSEIN KHAN	DR. ITIMAD ED
(Out-patients and	MOGADDAM	SAIFI	DOWLEH
Anæsthetist).	(In-patients).	(Pathologist).	(Accountant).

*Front row :*

MISS S. E. OXLEY	DR. A. R. NELIGAN.	DR. HAKIM ED	DR. J. SCOTT.	MISS L. A. HEATH.
(Matron).		DOWLEH		
		(Director).		

These last we converted into excellent wards, and later on we set aside the compound for women patients.

The out-patient department occupied part of the west side of the courtyard, and consisted of waiting rooms for men and for women, a consulting room, and a fine large room used for dressings and septic operations, with a tiled floor and wash basins with taps. It was unventilated, however, and the heat and smell in summer were most trying. The out-patients entered at the main gate and traversed the whole Hospital before reaching the department—an obvious nuisance.

be distributed by hand. Think, O reader, what this means! We could, as a matter of fact, arrange our own supply had we pipes, but we have not, and we are some five hundred miles from the nearest railway station. I have actually seen an enthusiastic European laying down old rifle barrels, which he had had "threaded," after removing the cartridge chamber, and then screwed one into the other. The use of steel piping on a large scale presented financial difficulties, however, with which we were not able to deal! The theatre is entered through an anæsthetic room tiled in the same way.

There were forty-two beds and twenty-five patients, most of them chronic cases. Two rooms were given up to V.D., and there were the lunatics. I cannot omit a description of their cells. There were eight of them, each nine feet by five, opening on a long narrow corridor, closed at one end by a huge iron gate, and close to the general wards. The cells again had each a heavy iron barred gate, which gave them the appearance of a row of dens for wild animals. In two of them we found immensely heavy wood and iron stocks, one of them made to take several people—apparently the only means of restraint. The mental case is a very serious difficulty here, and no doubt these cells had helped

Augean stables, etc. I can only mention a few of the problems which faced us. Reference has been made to the nursing question. Conservancy: No system of refuse disposal, the principal latrine soaking into the water supply of a whole quarter of the town (I had often heard Persians say that they never drank that water!); an open pit beneath the kitchen window received the *dejecta* of the operating rooms and surgery. Drinking water: Source obviously polluted; patients frequently contracted dysentery while in, and one of the staff nearly died of dysentery shortly after we took over. Instruments: Not enough for the smallest operation; eight rusty Spencer-Wells forceps, for



THE COURTYARD.

to solve many a problem in a rough and ready way. 'An asylum had recently been opened, however, and their unfortunate occupants were removed to it by our advice, and the cells put to other uses.

Strangely enough there was no separate section for women, and we found that very few consented to enter the Hospital as in-patients.

The staff consisted of the Director, whose duties at Court apparently allowed him little time for the Hospital; two young Persian doctors, trained at Tehran, who, with the assistance of two resident medical students, did all the clinical work; an elderly accountant; a number of male "nurses" and one female "nurse," who knew nothing of nursing, but several of whom were adepts at preparing an opium pipe! and servants.

Our first inspection of the institution left us talking of

instance, did duty for all kinds of work; bowls, trays, ligature and suture material, splints, etc., almost non-existent. Linen room practically empty. No laboratory, dispensary or mortuary. Laundry and bathroom quite inadequate. At the time too, of which I am writing—the summer of 1919—war conditions still held at Tehran, extremely high prices, no imports, and articles of European origin therefore fantastically expensive, transport from abroad very slow and costly. However, the Persian Government, when we entered on our duties, had substantially increased the Hospital budget so as to make it more nearly conform with the increased cost of living; our Government was ready to help with *matériel*, and "supplies" at Bagdad and Kazvin allowed us to purchase some urgently needed stores.

As regards the structure, we reported to the Persian

Government that it would be unwise to incur the heavy expenditure necessary to make the best of it, and advised that only necessary and urgent works should be carried out, and that a modern hospital should be built on another site. This view was accepted, as were, indeed, all our proposals, but the new hospital, alas! has still to be begun. And so we cleaned, painted, ventilated and repaired; made new latrines, a bathroom, a laundry and a dispensary; out-patient entrance and exit, laboratory, shelter for open-air treatment and a mortuary. A cart to bring water from the British Legation was started. A sewing-room under the Colony's trained nurse made sheets, garments, etc. The bazaars fell to and turned out Hospital furniture, from instrument tables to spittoons, sterilisers to stretchers, temperature charts to squeegees made from old motor tyres. Instrument stores and apparatus were ordered from home (they arrived two years later!). Dr. Woollatt, who was acting for Scott, and I composed a pharmacopœia (in French by the way!), in which figure not a few old friends from Bart.'s, in company with strange companions such as "Injection intraveineuse de quinine" and "Pommade d'antimoine" (for oriental sore). Special departments were also started—"Eyes," "V.D." and "Throat and Ear." Among our first clinical assistants was one from Moorfields, another was M.D. London and a third was a Prince!

Most important of all, the Persian Government gave permission to engage a Matron. The Overseas Nursing Association sent us Miss S. E. Oxley, late of Westminster Hospital. She has trained orderlies, and two Persian girls who wear correct uniform and work unveiled—a triumph indeed! We have a women's section now with twenty beds, and they are always full. Further, it was arranged that the nurse of the British Colony should live with the matron and help in the work and teaching.

One of our duties is to give clinical teaching to the student of the Persian Medical School. This is a state school (education free), and is now the only licence-giving authority in the country. The lecturers are nearly all Persians (some of whom have studied in France), but include two French doctors. The teaching is entirely theoretical, and the school has next to no equipment. There is no compulsory programme of clinical instruction, and until last year the French doctors had no hospital for teaching purposes. We hope with them to yet make clinical work obligatory. It is a most unfortunate position in a country where practical men are so badly needed as they are in Persia. We very early started out-patient dresserships and drew up a regular programme of clinical work but the authorities have failed to enforce it. One of the chief difficulties is that the bulk of the students are poor, many come from distant towns, and they have to work for their living in the morning and attend lectures in the afternoon. This does not leave much time for hospital practice. Instruction is given in Persian or French.

Our work is exceedingly varied. My colleague and I share it, but he does all the eye work and I run the laboratory (now well fitted up and the proud possessor of the only guinea-pigs in Tehran) with a Persian assistant. On the medical side we rarely see rheumatic fever or its effects, though rheumatic affections, in spite of the dry climate, are very common; and while syphilis is wide-spread, it attacks the nervous and vascular systems much less frequently than in Europe. But malaria, pneumonia, dysentery and enteric fever keep us busy, and our admission list last year included typhus fever, relapsing fever, anthrax, tetanus, acute glanders and leprosy.

On the surgical side hernia, stone in the bladder (for which we crush), bone disease and cataract, or the results of trachoma, provide most of the operative work. Tuberculosis is rampant, especially of the bones and joints. The Persian has very poor resistance, and most of our cases reach us in the late stages with deformity and sinuses. Fortunately the climate is ideal for open-air and sun treatment. I saw two tuberculous joints in a wandering tribe while I was fishing in the mountains last summer. Malignant disease, except carcinoma of the breast and sarcoma of the jaws, is rare. This fact, and the rareness of appendicitis and of ulcers of the stomach and duodenum among Mohammedans and of industrial accidents (absence of machinery) cuts down the operation list as compared with London. On the other hand, accidents with firearms and bites from animals (panthers, wolves, camels and so on) help to keep the sterilisers going. I had forgotten hepatic abscess; it is a common disease here but we seldom have to do an open operation: aspiration followed by the injection of emetine or quinine is better for both patient and doctor. A hod-carrier, whose liver held six pints of pus at the first aspiration, has been treated recently and has returned to his work.

Rickets is almost non-existent here, and so we have few obstetric operations to do. Diseases of the ovaries and Fallopian tubes are the most common reasons for abdominal section.

We can now take in eighty patients. Our work suffered much last year for the same reasons that hospitals at home suffered, namely, lack of funds. This is a poor country and has been hard hit by the depression in trade. A fund started by Lady Cox, when her husband, Sir Percy Cox, was British Minister, has enabled us to tide over a bad time and to help many poor patients on their discharge.

Our great need is X-ray and electro-therapeutic apparatus, and only the local political and financial situation has prevented our bringing them out. Recently our chief difficulty has been solved by the generosity of H.H. Prince Farman Farma, who has offered to put up and maintain the necessary buildings at his own expense. We hope, therefore, to have an up-to-date department before long, with a Persian who has specialised in Paris in charge of it.

The Prince, who is known in Persia for his generosity to hospitals, has also offered to build and maintain a V.D. clinic and ward. He is setting a shining example which we hope will be followed by many of his countrymen, both here in the capital and in the provinces in the case of other hospitals.

This hospital is not the only one in Tehran. The American Mission has a well-built hospital with forty-five beds for men and ten for women, two doctors, one of them a lady, and a trained nurse. A hospital with thirty beds was started last year for the French professors. There is also a hospital for women and children under a French lady doctor, but it is badly equipped and is practically an out-patient department. The Bahais have a small hospital, and there are the military and police hospitals. Recently the Tehran municipality started a hospital which is to have eventually a hundred beds, as well as a series of treatment centres for the poor scattered about the city. The British Government has maintained for very many years a well-equipped dispensary in both the Tehran and the summer Legations, which is very largely attended by the poor, who receive free treatment and medicine.

### ROUND THE FOUNTAIN.

STUDENT: "Well, we'll just give you a whiff of gas . . ."

PATIENT: "No you won't, guv'nor; I've got gastritis as it is."

\* \* \*

"I'd been examining the case and the Examiner came along.

"Well, what is it?' says he.

"Varicocele,' says I.

"Why?' says he.

"Bag o' worms,' says I.

"What sort o' worms?' says he.

"And the only sort I could think of was *Ankylostoma duodenale*."

\* \* \*

A medical man in Russia was recently called out to a case at night, was knocked on the head and eaten. Well, well! A doctor's lot is not a happy one.

### REVIEWS.

ANATOMY AND PHYSIOLOGY FOR JUNIOR NURSES. By FELICIE NORTON. (London Scientific Press, Ltd.) Illustrated. Pp. 73. Price 2s. 6d.

This is a book for the probationer nurse. It contains sound but extremely elementary teaching. One wonders whether it is not too condensed to be interesting to one just beginning the study of anatomy and physiology. The illustrations are, on the whole, good, but we strongly advise the inclusion of a diagram of the renal tubules and circulation in any further edition.

HINTS TO PROBATIONER NURSES IN MENTAL HOSPITALS. By RICHARD EAGER, O.B.E., M.D. (London: H. K. Lewis & Co., Ltd.) Pp. 80. Price 1s. 6d.

An excellent little book dealing with the duties of nurses in this special department and with its emergencies. Half the book is an elementary account of modern psychology.

DE ARTE PHISICALI ET DE CIRURGIA OF MASTER JOHN ARDERNE, SURGEON OF NEWARK. Dated 1412; translated by Sir D'ARCY POWER, K.B.E., M.B.(Oxon.), F.R.C.S., from a transcript made by ERIC MILLAR, M.A.(Oxon.). (London: John Bale, Sons & Danielsson, Ltd.) Coloured Frontispiece and 13 Plates. Pp. 57. Price 10s. 6d. net.

This book is published under the auspices of Mr. Henry S. Wellcome, of the well-known firm of Messrs. Burroughes & Wellcome, and is the first of their volumes of research studies in medical history. It gives us the very greatest pleasure to see a great business house in this country contributing to literature and science.

John Arderne was an operating surgeon of Newark between 1349 and 1370, and his practice lay amongst the nobility, wealthy landowners and the higher clergy. He was himself well educated though a layman, and he met his patients on terms of equality. He was perfectly honest, and kept so open a mind that he says more than once, after stating his own practice, "never the less do another man as him thinketh better." He had sufficient originality to invent the operation for the cure of fistula, which, after falling into disuse for nearly five hundred years, is now universally employed. The present volume is largely composed of translations of his prescriptions, always quaint and often horrible: "*Against matted glands*: Ground ivy ground up and infused with oil of cummin plastered on. Also goats' dung with vinegar is useful if it is employed as a plaster."

In his instructions in midwifery he shows himself well ahead of his time. There is little which he advises which may not be done to this day.

The illustrations of the original documents are admirable. The book is a delight.

AIDS TO BACTERIOLOGY. By WILLIAM PARTRIDGE, F.I.C. (London: Baillière, Tindall & Cox.) Pp. viii + 276. Price 5s. net.

It is a curious fact in the ever-popular "Aids" series that while the volume in one subject may with difficulty be sufficient for, say, the college examinations, another volume—and such a one is this before us—may be sufficient for a much more advanced test.

Mr. Partridge has done his work well, as the fourth edition of his book testifies. In the present volume such recent work as Petroff's medium, the egg-broth, Gordon and Hine's pea-flour agar are described. It is a book we can heartily commend to students reading for an examination in which bacteriology is a subsidiary subject.

### RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

ADAMSON, H. G., M.D. "Sporotrichosis (with Cultures)." *Proceedings Royal Society of Medicine*, March, 1922.

BLAIR, C. J. LOWMOUTH. "Lobulated White Mass at Macula." *Ibid.*

BOURN, GEORGE, M.D. "A Simple Portable Apparatus for Continuous Oxygen Administration." *British Medical Journal*, July 8th, 1922.

BROWN, W. LANGDON, M.D. President's Address, "The Threshold of the Kidney." *Ibid.*

CAMMIDGE, P. J., M.D. "The Source of the Amyolytic Ferment of the Urine." *Ibid.*, June, 1922.

— "The Aetiology of Diabetes and its Bearing on Treatment." *Practitioner*, June, 1922.

CAUTLEY, EDMUND, M.D., F.R.C.P. "Proprietary Food and Milks." *Ibid.*, July, 1922.

CHANDLER, F. G., M.D. "The History of the Diagnosis and Treatment of Empyema." *Proceedings Royal Society of Medicine*, February, 1922.

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COCKAYNE, E. A., M.D. "Case of Defective Ossification of Skull." *Ibid.*, May, 1922.

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- GORDON, M. H., Hon. Lt.-Col., C.M.G., C.B.E., M.D. "The Filter-Passer of Influenza." *Journal Royal Army Medical Corps*, July, 1922.
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- "Case of Double Myxo-sarcoma of the Face." *Ibid.*

\* \* \* Examinations, etc., are unavoidably held over.

### CHANGES OF ADDRESS.

- BEADLES, Lt.-Col. H. S., R.A.M.C., P.M.O. Gendarmerie, Surafend Camp, Ludd, Palestine.
- BURNE, T. W. H., The General Hospital, Johore Bahra, Malay States.
- GRIFFITH-JONES, C., 38, Finedar Road, Wellingborough.
- HOGGEN, G. HAMILTON, Charing Cross Hospital, S.W. 1.
- HOLGATE, Major M. J., I.M.S., 55, Fellows Road, Hampstead, N.W. 3. (Temporary.)
- KELF, H. D., 71, Trafalgar Road, Greenwich, S.E. (Tel. Greenwich, 688).

- TOMS, H. W., Assistant to M.O.H., Local Sanitary Office, Bangkok.
- WHITBY, F., Dymchurch, Kent.
- WHITE, F. NORMAN, Chief Commissioner, Epidemic Commission, League of Nations, Geneva, Switzerland.
- WILLIAMS, R. HARVEY, "Lisnamoe," The Avenue, Hitchin.

### APPOINTMENTS.

- COLE, B. H., M.R.C.S., L.R.C.P., appointed House Physician at the Royal Berkshire Hospital, Reading.
- HILL, N. H., M.B., B.S.(Lond.), M.R.C.P., appointed Assistant Physician to the Metropolitan Hospital.
- HOGGEN, G. HAMILTON, M.R.C.S., L.R.C.P., appointed House Surgeon at Charing Cross Hospital.
- STURTON, C., M.R.C.S., L.R.C.P., appointed House Surgeon to Salisbury General Infirmary.
- THOMAS, C. HAMBLE, M.B., B.S.(Lond.), appointed Chief Assistant, Ear, Nose and Throat Department, West London Hospital, and Aural Specialist to the Ministry of Pensions.
- TOMS, H. W., M.B., B.Ch.(Oxon.), appointed Assistant to Medical Officer of Health, Bangkok.

### BIRTH.

- WILLIAMS.—On April 20th, 1922, at Lisnamoe, The Avenue, Hitchin, to the wife of R. Harvey Williams—a daughter.

### MARRIAGES.

- BATTERHAM—RUNDLE.—On August 3rd, at St. Mary's, Rolvenden, by the Rev. G. Andrew (Vicar) and the Rev. Canon Beale (Vicar of Sandhurst and Newenden), Capt. Douglas John Batterham, son of Dr. Batterham, of Beechfields, Northiam, to Ethel Thelma Rundle, only daughter of Dr. and Mrs. F. Carlyon Rundle, of the Old Parsonage, Rolvenden.
- GRIFFITH-JONES—GOODING.—On August 2nd, at Mount View Congregational Church, Stroud Green, N., by the Rev. Dr. E. Griffith-Jones, father of the bridegroom, assisted by the Rev. W. E. Cloutman, Dr. Cyril Griffith-Jones to Dorothy May, daughter of Mr. and Mrs. E. R. Gooding.

### DEATHS.

- CROSS.—On August 28th, at 49, West Heath Drive, N.W. 11, in his 87th year, William Henry Cross, B.A., J.P., for 38 years Clerk to the Governors of St. Bartholomew's Hospital.
- JENKINS.—On August 6th, 1922, at 11, Hills Place, Oxford Street, W., Dr. T. J. Price Jenkins, aged 58.
- PLETTS.—On August 5th, 1922, at his residence, Bedford, John Menham Pletts, M.D., etc., formerly of Ryde, Isle of Wight, aged 72.
- RAWLING.—On July 24th, 1922, Sarah Bathe Rawling, of 16, Montagu Street, Portman Square, aged 74.
- STACK.—On August 3rd, 1922, at King's College Hospital, London, Edward Hugh Edwards Stack, M.B., F.R.C.S., of Clifton, Bristol, aged 55.
- STEVENS.—On August 20th, 1922, at Gaya, India, from cholera, Lt.-Col. Algernon Francis Stevens, I.M.S., third son of the late Sir Charles Cecil Stevens, K.C.S.I., and Lady Stevens.
- VINCENT.—On July 21st, 1922, at 32, Seymour Street, Ralph Vincent, M.D., eldest son of Ralph Vincent, of Leytonstone.
- WEATHERALL.—On August 1st, 1922, killed in motor cycle accident, Estlin Hugh Weatherall, M.B., B.S.(Lond.), House-Physician, St. Bartholomew's Hospital, and of Essex Manse, Kensington, aged 24.
- WILCOX.—On August 14th, 1922, of heart disease, Ernest Wilcox, M.D., M.R.C.S., C.M., Hambrook Court, Glos., beloved husband of Minnie Wilcox (née Hustler).

### NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, Smithfield, E.C.

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